



627-B North Marietta Parkway
Marietta, GA 30060
Phone: (770) 794-5229
Fax: (770) 794-2286

Backflow Serial No: _____
Test Date/Time: _____
Tester Certification: _____
Device Test Result ☐ Pass ☐ Fail

Backflow Prevention Device Test & Maintenance Report

(Please Print)

Account	Business Name: _____	Marietta Water Use Only	
	Address: _____	Location ID: _____	
	City: _____ ST: _____ Zip: _____		
	Phone: _____ Contact: _____	Meter No: _____	

Device	Make: _____ Model: _____ Size: _____			
	Type: <input type="checkbox"/> RP <input type="checkbox"/> DC <input type="checkbox"/> DCDA <input type="checkbox"/> PVB <input type="checkbox"/> AVB <input type="checkbox"/> SVB <input type="checkbox"/> Air Gap			
	Date Installed: _____ Location on property: _____			
	<input type="checkbox"/> New <input type="checkbox"/> Existing	<u>Orientation</u> <input type="checkbox"/> Horizontal <input type="checkbox"/> Vertical <input type="checkbox"/> Installed Properly (VB/AG)	<u>Service</u> <input type="checkbox"/> Domestic <input type="checkbox"/> Fire <input type="checkbox"/> Bypass <input type="checkbox"/> Irrigation	<u>Protection</u> <input type="checkbox"/> Containment <input type="checkbox"/> Isolation (specifics below)
	Previous Device Serial No: _____			

	Initial Test Results		Repairs/Comments	Re-Test Results	
	Tightness	Differential		Tightness	Differential
Check Valve #1 (RP, DC, VB)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight			<input type="checkbox"/> Leak <input type="checkbox"/> Tight	
Check Valve #2 (RP, DC)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight			<input type="checkbox"/> Leak <input type="checkbox"/> Tight	
Relief Valve (RP)	opened at			opened at	
Buffer (#1-relief) (RP)					
Air Inlet (VB)	opened at			opened at	
Shutoff Valve #1	<input type="checkbox"/> Leak <input type="checkbox"/> Tight			Line Pressure: _____	
Shutoff Valve #2	<input type="checkbox"/> Leak <input type="checkbox"/> Tight				
Comments: _____ _____ _____					

Notification	Alarm Company/Fire Department Notified: _____	
	Person Notified: _____	Notified By: _____
	Turn Off Date/Time: _____	Turn On Date/Time: _____

Test Kit	Test Kit Make: _____ Model: _____
	Serial No: _____ Last Calibration Date: _____

Tester	Tester Name: _____	Certificate Expiration Date: _____
	Company: _____	Phone No: _____
	Tester certifies that these data are accurate (true) and reflect the proper operation, test and/or maintenance of this assembly. Tester also verifies that isolation valves were returned to pre-test orientation.	
	Signature: _____	